HEALTH INSURANCE PREMIUM PAYMENT PROGRAM
MEDICAL QUESTIONNAIRE

SECTION 6 - INSTRUCTIONS: Applicant: Fill out form completely to the best of your knowledge. "Family" refers to those members of your household who are eligible for coverage under the Employee's health insurance**. Please sign at the bottom of this page.** ***This information is maintained in complete confidentiality.***

Caseworker: please fill out this section only.

Name of Applicant:	Medicaid ID Number:
Name of Caseworker:	Caseworker ID Number:

Applicant: please fill out information below this point.

1. Have you or other members in your family (those who are eligible for coverage under the Employee's health insurance) been hospitalized in the past two years? ☐ Yes ☐ No

   Name: _____ Reason: _____ How many times? _____

2. Do you or other members in your family require regular doctor's visits? ☐ Yes ☐ No

   Name: _____ Reason: _____ How many times? _____

3. Are any of your family members periodically institutionalized or living in an institution (mental health home, nursing home, hospital, etc.)? ☐ Yes ☐ No

   Name: _____ Type of Residence: _____

4. Do you or any of your family members have any of the following medical conditions which requires medical care? Check all conditions that apply:

✓	CONDITION	NAME OF PERSON WITH THIS CONDITION	HOW OFTEN IS MEDICAL CARE REQUIRED?
	Pregnancy		
	Diabetes		
	Blood Disorder		
	Cancer		
	Mental Illness		
	Mental Retardation		
	Heart Condition		
	Asthma or other respiratory ailment		
	Back Problems or Scoliosis		
	Stroke or Head Injury		
	Birth Defects		
	Kidney or Liver Disorder		
	Cerebral Palsy/Multiple Sclerosis		
	Seizure Disorder		
	Attention Deficit Disorder		
	Alcoholism/Drug Addiction		
	HIV Positive		
	Other disease or condition requiring treatment (Describe)		

SECTION 7 – *Applicants' Signature* _____ ***Date*** _____

All information obtained from this form is used only for processing of the application and is maintained with complete confidentiality.

Remember to sign Section 12 of the Employer Insurance Verification form before giving to your Employer.